The Roots of Health

CranioSacral Therapy, Therapeutic Massage, Reiki
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Infant Client Intake Form (birth to 1 yr old)

Client Information

Infant Name: _____ Today's Date: _____

Date of Birth: _____ Current Age: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Primary Caregiver's Phone: _____ Email: _____

Home Address: _____ Home Phone: _____

City: _____ State: ____ Zip: _____

Referred By: _____

Primary Physician Name and Phone: _____ (____) _____

Emergency Contact Name and Phone: _____ (____) _____

Unless specifically noted otherwise, provision of contact information assumes permission for The Roots of Health to contact you with questions or information related to your therapy, general information, or promotional offers.

General Information

Describe your primary concern(s) regarding your child. _____

_____

_____

_____

At what age did you first become concerned? _____

On a scale of 1 to 10 (1 being the least), what is the amount of stress/tension in your life? _____

Anything else that would be helpful for you to share? _____

Medical Information

Currently under care of health practitioner for a specific condition/illness? ___ Practitioner's name: _____

Condition/Illness: _____

List current medications and purposes: _____

_____

List injuries/accidents/illness. Please circle any still affecting infant: _____

_____

Surgeries & hospitalizations: _____

_____

List any allergies (food and nonfood): _____

Did / does your child suffer from frequent ear infections? If yes, list number since birth.:

_____

PRENATAL / BIRTH HISTORY

History of pregnancy (i.e. medication, health of mother, complications):			
Maternal Age at birth			
Number of previous pregnancies			
Number of children			
Ages of children			
Length of pregnancy	Full Term		Weeks Gestation
	Premature		Weeks Gestation
Note complications of pregnancy.			
Type of delivery	Vaginal	C-Section	Breech (feet first)
Note complications of labor/delivery, including medications and/or epidural			
Birth weight			
Require hospital stay at NICU?			
Please describe hospital stay and length of time			

CHILD'SBIRTH

Was or did child...	Full term?	Yes	No
	Length of gestation		
	Premature?	Yes	No
	Length of gestation		
	Postmature/Prolonged Pregnancy	Yes	No
	Length of gestation		
	Require manual birth assistance?	Forceps	Vacuum Extraction
	Suctioning at birth?	Mouth	Nose
		Lungs	Stomach
	Cord around neck?	Yes	No
	Have sufficient oxygen?	Yes	No
	Have respiratory problems?	Yes	No
	Need a respirator?	Yes	No
	If yes, how long?		
	Small for gestational age?	Yes	No
	Have a heart defect?	Yes	No
	Have jaundice?	Yes	No
	If yes, how long?		
	Have congenital abnormalities?	Yes	No
	If yes, please describe		
	Have seizures?	Yes	No
	Have infections?	Yes	No
	If yes, type of infections?		
	Have surgery as newborn?	Yes	No
	Have feeding problems as a newborn?	Yes	No
	Receive vaccines	Yes	No
	If yes, which ones?		
	Vaccine complications/injury? If yes, please describe		

SPEECH-LANGUAGE DEVELOPMENTAL HISTORY

Is your infant…	A quiet baby?	Yes	No
	A frequent crier?	Yes	No
	Irritable?	Yes	No
	Visually alert / attentive?	Yes	No
	Auditorily alert / attentive?	Yes	No
At what age did your child…	Babble?		
	Understand speech sounds?		
	Imitate speech sounds?		
	Say first words?		
	Use two or more words in a phrase?		
Did your child begin to babble then stop?	Yes, at age _	No	

COORDINATION / MUSCLE TONE

Is infant	Hypertonic (tense, arms contracted into body, scissoring of legs)	Yes	No
	Hypotonic (floppy, low muscle tone for age)	Yes	No
Did / does your infant have difficulty…	Sucking?	Yes	No
	Swallowing	Yes	No
	Chewing?	Yes	No
	Changing to solids?	Yes	No
Does infant…	Sit, stand or walk late?	Yes	No
	Was creeping and crawling phase unusually prolonged?	Yes	No
	Was creeping and crawling phase almost entirely omitted?	Yes	No
	Have any diagnosed muscle problems?	Yes	No

BEHAVIOR/TEMPERAMENT

Is infant…	Quiet, calm, relaxed, patient?	Yes	No
	Active, outgoing, enthusiastic?	Yes	No
	Intense, demanding?	Yes	No
	Seem hyperactive, in perpetual motion all the time?	Yes	No
	Upset by transitions/unexpected changes?	Yes	No
	Passive, quiet, withdrawn?	Yes	No
	Rigid, set in his/her ways?	Yes	No
	Regular sleep patterns?	Yes	No
	Difficult to get to sleep?	Yes	No
	Destructive with toys?	Yes	No
	Short attention span?	Yes	No
	Very cautious/ afraid to try new things?	Yes	No
	Nearly impossible to take to the movies, church/temple or other settings?	Yes	No

ADDITIONAL COMMENTS FROM INFANT'S CARETAKER:

Because both Rachel Benbow and Ian Thomas, both here after referred to as the "therapist," must be aware of existing medical conditions, I have stated all my known medical conditions and medications, and take it upon myself to keep the therapist informed about my updated physical health.

- I understand that the therapist cannot diagnose illness, disease, or any other medical, physical, psychological, or emotional disorder. I am responsible for consulting a qualified physician or medical practitioner for any physical/psychological ailments that I have.
- I understand that services offered by the therapist are not a substitute for medical care, and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature.
- I understand that Massage Therapy, CranioSacral Therapy and Reiki are therapeutic health aids.
- I understand that massage/bodywork is not appropriate care for infections or contagious illnesses or conditions. I will cancel my appointment as soon as I am aware of an infections or contagious illness or condition.
- I understand that the consumption of alcohol, recreational drugs, and pain killer pharmaceuticals can dangerously alter my body's ability to register and give feedback about pain or other vital sensations. Consumption of these items can also create detrimental and potentially deadly reactions when combined with massage/bodywork. I agree to NOT consume alcohol, recreational drugs or pain killer pharmaceuticals prior to any treatment sessions.
- I understand that post treatment soreness can occur by the evening following a treatment session, and may last into the next day. In a small percentage of cases, soreness can last up to three days. Discomfort following treatment may be in an area that was treated, or in another area that is connected through a fascial restriction. The body's tissues can experience discomfort during the post-treatment period due to release of restrictions and reorganization of the tissue. Drinking plenty of water and getting rest may help to minimize the temporary discomfort experienced following a treatment session.
- I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized, and I will pay for the fully scheduled session.
- I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.
- I understand that the therapist is a volunteer responder for the CSMT Emergency Response Division, and that there may be rare occasions when the therapist may have to cancel and reschedule my session at short notice in order to assist at state or national emergencies/disasters.
- I understand that I will be charged, and agree to pay, a $2.75 processing fee when using a credit or debit card to pay for services or products. There are no additional fees for paying with cash or check.
- I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment.
- I understand that I will not hold this establishment or therapist liable for anything related to this treatment.
- I agree to actively participate as much as possible in my own healing.

_____ _____

Client or Parent/Guardian Signature Date